Health History

Kevin Finnerty D.D.S

Patient Information

Date: __/__/__

Patient Name:______________________________
Last Name First Name M.I.

Address:___________________________________
City:_____________________________________
State:______________________Zip:__________
Sex: ☐ M ☐ F
Birthdate: __/__/__
☐ Married ☐ Single ☐ Minor ☐ Other
SSN:_____________________________________
E-Mail:___________________________________
Home Phone: (___) _________
Work Phone: (___) __________
Cell Phone: (___) ___________
Patient Employer/School:__________________
Occupation:______________________________

IN CASE OF EMERGENCY, CONTACT (someone who does not live in your household)

Name:_________________________
Relationship:___________
Home Phone: (___) ___________
Work Phone: (___) ____________

Whom may we thank for referring you?:

____

Insurance Information

Who is responsible for this account:____________
Relationship to Patient:______________________
Insurance Co.:_______________________________
Group #:____________________________________
Is patient covered by additional insurance?
☐ Yes ☐ No
Subscriber's Name:___________________________
Birthdate:______________
SSN:___________________
Relationship to Patient:______________________
Insurance Co.:_______________________________
Group #:__________________________________

ASSIGNMENT AND RELEASE

I certify that I, and/or my dependent(s), have insurance coverage with _________________ and assign directly to Dr. ________________all insurance benefits. I understand that I am financially responsible for all changes whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

The above-named dentist may use my health care information and may disclose such information to the above-named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services.

____
Signature of Patient, Parent, Guardian or Personal Representative

____
Date Relationship to Patient

Dental History

Reason for today's visit:____
Former Dentist:____________________
City/State:________________________
Date of last dental visit:_ _/__/__
Date of last dental x-rays:__/__/__
Circle "yes" or "no" to indicate if you have had any of the following:

Bad breath	Yes	No
Bleeding or tender gums	Yes	No
Blisters on lips or mouth	Yes	No
Burning sensation on tongue	Yes	No
Cigarette, pipe, or cigar smoking	Yes	No
Clicking or popping jaw	Yes	No
Dry mouth	Yes	No
Food collection between teeth	Yes	No
Grinding teeth	Yes	No
Jaw pain or tenderness	Yes	No
Loose or broken teeth/fillings	Yes	No
Mouth breathing	Yes	No
Orthodontic treatment	Yes	No
Pain around ear	Yes	No
Periodontal treatment	Yes	No
Sensitivity to cold	Yes	No
Sensitivity to heat	Yes	No
Sensitivity to sweets	Yes	No
Sensitivity when biting	Yes	No

How often do you floss? ______________
How often do you brush?______________

Health History

Please circle “yes” or “no” if you have had any of the following:

Condition			Condition		
AIDS	Yes	No	Hepatitis Type______	Yes	No
Anemia	Yes	No	Herpes	Yes	No
Arthritis, Rheumatism	Yes	No	High Blood Pressure	Yes	No
Artificial Heart Valves	Yes	No	Jaw Pain	Yes	No
Artificial Joints	Yes	No	Kidney Disease	Yes	No
Asthma	Yes	No	Liver Disease	Yes	No
Bleeding abnormally,	Yes	No	Low Blood Pressure	Yes	No
with extractions or surgery			Mitral Valve Prolapse	Yes	No
Blood Disease	Yes	No	Pacemaker	Yes	No
Cancer	Yes	No	Psychiatric Care	Yes	No
Chemical Dependency	Yes	No	Radiation Treatment	Yes	No
Chemotherapy	Yes	No	Respiratory Disease	Yes	No
Circulatory Problems	Yes	No	Rheumatic Fever	Yes	No
Cortisone Treatments	Yes	No	Scarlet Fever	Yes	No
Cough, persistent or bloody	Yes	No	Shortness of Breath	Yes	No
Diabetes	Yes	No	Sinus Trouble	Yes	No
Emphysema	Yes	No	Stroke	Yes	No
Epilepsy	Yes	No	Swollen Feet or Ankles	Yes	No
Glaucoma	Yes	No	Swollen Neck Glands	Yes	No
Headaches	Yes	No	Tonsillitis	Yes	No
Heart Murmur	Yes	No	Tuberculosis	Yes	No
Heart Problems	Yes	No	Ulcer	Yes	No

Physician’s Name:_____________________________________ Date of last visit:_____________________

Have you ever taken any of the group of drugs collectively referred to as bisphosphonates? These include Fosamax, Actonel, Boniva, Aredia, Zometa, Didronel. Yes No

Women:

Are you pregnant? Yes No Due Date:_______ Are you nursing? Yes No

Taking birth control pills? Yes No

Medications

List any medications you are currently taking and the correlating diagnosis:______________________________

____

Pharmacy Name:______________________________

Phone: (___)______________

Allergies

- [ ] Aspirin
- [ ] Penicillin
- [ ] Codeine
- [ ] Sulfa
- [ ] Latex
- [ ] Other:__________
- [ ] Local Anesthetic

AUTHORIZATION

I (WE) AUTHORIZE TREATMENT BY THE DOCTOR AND SUPPORTING STAFF MEMBERS.
I (WE) UNDERSTAND THERE MAY BE A MINIMUM CHARGE OF $50.00 FOR APPOINTMENTS THAT ARE BROKEN WITHOUT 24 HOURS NOTICE. ($50 per hour)
I (WE) AUTHORIZE ASSIGNMENT OF INSURANCE BENEFITS WHEN APPLICABLE. IF THE INSURANCE COMPANY FAILS TO MAKE PAYMENT WITHIN 8 WEEKS, I WILL ACCEPT FULL RESPONSIBILITY FOR THE ENTIRE BALANCE ON THE ACCOUNT.
I (WE) ASSUME FULL RESPONSIBILITY FOR ANY BALANCE OF CHARGES NOT COVERED BY THE INSURANCE COMPANY AND AGREE TO PAY MY ESTIMATED PORTION DUE AT THE TIME OF SERVICE.
I (WE) AM/ARE AWARE THAT THERE IS A MINIMUM FEE OF **$25.00** FOR RETURNED CHECKS.
I (WE) ACCEPT FULL RESPONSIBILITY FOR AND ALL LEGAL FEES FOR COLLECTION SHOULD MY ACCOUNT BECOME DELINQUENT.
I (WE) UNDERSTAND THAT A BILLING CHARGE OF 1.5% THE BALANCE WILL BE ADDED TO MY ACCOUNT EACH MONTH FOR BALANCES THAT ARE PAST DUE.
PLEASE NOTE: LEGAL FEES RANGE FROM **33.33%-50%**. COURT FEES **START** AT **$53.00.**

PATIENT'S SIGNATURE___________________________________ DATE____________________